Testimony before the Human Services Committee

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Good morning, Senator Slossberg, Representative Abercrombie and distinguished members of the Human Services Committee. My name is Roderick Bremby and I am the Commissioner of Social Services. I appear before you today to testify on several bills that would impact the department.

Proposed S.B. No. 594 AN ACT CONCERNING RESTORING MEDICAID REIMBURSEMENT LEVELS FOR EMERGENCY AMBULANCE TRANSPORTATION.

This proposal would increase Medicaid reimbursement rates for ambulance transportation. Rates were reduced beginning in 2011 as part of budget cost savings measures and this bill would restore the rates to the 2010 levels. Funding has not been allocated for this purpose therefore the department cannot support the proposal.

Proposed S.B. No. 595 AN ACT CONCERNING EQUALIZING SUPPORT FOR CHILDREN WHO "AGE OUT" OF SERVICES.

The intent of this bill is to extend the services currently provided to foster children who "age out" of the Department of Children and Families' services to those children being raised by nonparent family members who "age out" of assistance provided under DSS' Temporary Family Assistance program. The department cannot support this proposal as funding has not been allocated in the Governor's budget for this purpose.

Proposed H.B. No. 5069 AN ACT REDUCING HEALTH CARE FRAUD, WASTE AND ABUSE.

The department has a long history of aggressively pursuing fraud, waste and abuse in the various Medical Assistance programs. The DSS Office of Quality Assurance (QA) is responsible for ensuring the fiscal and programmatic integrity of all programs administered by DSS as well as all administrative functions of the department. The division is committed to the belief that program integrity can be best achieved through the fair application of proactive, creative, and coordinated initiatives designed to both prevent and recover improper payments.

QA has four separate divisions, each with unique program integrity functions. The four divisions are: Audit, Investigation, Resources & Recoveries, and Quality Control. There are currently 160 staff members and more positions are in the process of being filled. The current staffing level reflects a recent reorganization that centralized 65 Regional Office client fraud investigators under the control of QA.

Overall in SFY 2012, QA identified over $380 million in cost avoidance, overpayments, and third party recoveries.

The Audit Division

The Audit Division performs several audit related functions. The Provider Audit Unit is responsible for conducting federally mandated audits of medical and health care providers that are paid through the various medical assistance programs funded by the department. The vast majority of audits are aimed at Medicaid providers. The main purpose of these audits is to ensure and promote compliance with all applicable statutes and regulations. In some cases, our audit may reveal suspected Medicaid fraud. In such cases, the Audit Division will make a referral to the Investigations Unit for a more focused review, which could result in legal action brought by the Attorney General and/or Chief State's Attorney.

As required by the federal Deficit Reduction Act, the Centers for Medicare and Medicaid Services (CMS) has contracted with a Medicaid Integrity Contractor (MIC) to audit Medicaid claims paid by DSS. The Audit Division is responsible for coordinating and approving the audits performed by this contractor.

More recently, DSS has contracted with Health Management Systems, Inc. (HMS) to serve as the state's Recovery Audit Contractor (RAC), which is a requirement of the federal Patient Protection and Affordable Care Act. HMS has initiated audits and various paid claim reviews.

The MIC and RAC programs are intended to supplement to the QA audit process.

The Resources & Recoveries Division

The Resources & Recoveries Division ensures that DSS is the payer of last resort for the cost of a client's medical care. Section 1902(a)(25)(9A) of the Social Security Act requires states to take all reasonable measures to ascertain the legal liability of third parties to pay for services available under Medicaid. HMS (previously mentioned as the state's RAC contractor) is under contract with the department to perform third party liability and program integrity work. HMS performs comprehensive client health insurance identification matches, which are utilized to prevent the payment of claims and to recover on claims paid by Medicaid. In addition, HMS supports the joint DSS/DPH Connecticut AIDS Drug Assistance Program (CADAP), which through federal funding pays the health insurance premiums for CADAP clients. Finally, HMS performs acute care hospital and skilled nursing facility credit balance audits.

The Investigations Division

The Investigations Division is charged with targeting and investigating both provider and recipient fraud. This is achieved through the following efforts:

- Enhanced provider enrollment screening;
- Paid claim analysis and research;
- Complaint investigations, and
- Centralized recipient fraud investigations.

The department is required under federal regulations to refer matters of suspected Medicaid fraud and abuse to the Medicaid Fraud Control Unit (MFCU) of the Office of the Chief State's Attorney. Cases are only referred to the MFCU if the suspected fraud can be corroborated by our own review and

investigation. In addition to the MFCU, all fraud referrals are simultaneously sent to the OIG Office of Investigations and to the Office of the Attorney General. This procedure is in compliance with a Memorandum of Understanding between the Department and the three parties.

The Quality Control Division

As part of a national performance reporting system, DSS is required to conduct Quality Control reviews. The Quality Control Division (QC) is responsible for federally mandated reviews of the Care4Kids, Medicaid, and SNAP programs. A newly established set of federally required Medicaid reviews has been implemented under the Payment Error Rate Measurement (PERM) program. Reviews of Temporary Assistance to Needy Families cases and special projects may also be performed by this unit. QC reviews are conducted to determine the Department's compliance with federal and state program eligibility requirements.

Current Initiatives

The department is currently in the process of developing a state of the art fraud, waste and abuse system with the ability to perform predictive analytics to identify and prevent inappropriate claim payment. This system will be able to extend beyond claims editing to incorporate longitudinal analysis, clinical algorithms, and statistical/predictive analysis models that forensically analyze claims and provider behavior to identify potential fraud, waste and abuse.

This new solution can be integrated pre-pay or post-pay. With pre-pay, the multi-layer analytics extend MMIS edits to stop inappropriate claim payment. With post-pay, analytics target providers and claims for audit based on historical behavior.

The project, which is being fast-tracked, will have multiple benefits:

- Increased direct savings through recoveries and claim denials;
- Enhanced fraud, waste and abuse targeting;
- Comprehensive reporting;
- Streamlined system integration, and
- Guaranteed return on investment.

The bill before you addresses initiatives that currently exist or in the process of being developed. The department appreciates the emphasis that this Committee is placing on enhancing our ability to fight fraud, waste and abuse. However, we believe that the fast-track development of a state of the art fraud, waste and abuse detection system will accomplish all of the intended goals of this proposed legislation and, therefore, we feel it is unnecessary at this time.

Proposed H.B. No. 5106 AN ACT CONCERNING CHARGES FOR PATIENT CARE BY NURSING HOMES.

Nursing home rates are currently based upon an outdated, cost-based reimbursement system. This methodology typically sets one rate per facility and does not align payments to the actual services provided on a case-by-case basis. Converting to a Resource Utilization Group, or RUG, based reimbursement system would match reimbursement to the actual nursing and rehabilitation needs of the client. This reimbursement system is currently utilized by Medicare and pays different rates for residents according to case-mix adjustments, which are based on resident assessments. This type of reimbursement

system would also provide the Department with an improved capacity to reliably measure quality, efficiency and safety.

The Department agrees that there is a need to develop new reimbursement methodologies for a number of Medicaid provider types including nursing homes. In fact, the department is currently in the process of modernizing inpatient and outpatient hospital reimbursement methodologies.

While the Department is not opposed to implementing a more modern reimbursement methodology for nursing homes, and in fact, intends to do so, our current implementation of a new reimbursement methodology for inpatient and outpatient hospital rates is a major undertaking requiring significant departmental, consultant and stakeholder resources to implement.

Additionally, the state has embarked upon a significant nursing home rebalancing effort that will rebalance the state's long-term care system in order to keep more people in the community for longer periods of time. One of the anticipated results of this shift in service delivery will be an increase in the acuity of nursing home residents. It would be prudent to allow this initiative time to mature so we have a better understanding of the overall impact of the rebalancing effort on the long-term care system before we initiate a redesign of the reimbursement system.

The Department, therefore, strongly recommends that the initiative proposed in this bill not be undertaken until after the hospital reimbursement conversion is completed.

Proposed H.B. No. 5267 AN ACT CONCERNING THE REGIONAL DELIVERY OF SOCIAL SERVICES.

We applaud the proponent's interest in coordination of social services across state agencies, as it is a goal the department shares. However, as I discussed with this committee last week, the technological improvements and business process changes currently being undertaken at DSS will eradicate the need for regional boundaries defined by geography. Furthermore, geographic boundaries will not be recognized by the Health Insurance Exchange, which will share an integrated eligibility system with DSS for purposes of health care coverage. In addition, DSS' new eligibility management system will offer the opportunity for data sharing across agencies. Therefore, although well intentioned, we do not feel that this proposal is necessary or in line with the overall direction of social service delivery in Connecticut.

Proposed H.B. No. 5918 AN ACT CONCERNING PRIVATE DUTY NURSING FOR SEVERELY DISABLED CHILDREN.

This bill would require the Commissioner of Social Services to take whatever steps are necessary to provide private duty nursing as a covered service for children with severe disabilities who are enrolled in the HUSKY B program (non-Medicaid State Children's Health Insurance Program).

Extended nursing services are currently available under HUSKY B 'Plus,' when medically necessary, for children whose families are eligible for income bands 1 and 2. This bill would effectively extend this service to children enrolled in income band 3 as well. It is important to note that HUSKY B, income band 3, is a completely unsubsidized level of the Children's Health Insurance Program, with no family income ceiling for eligibility. As a result, and in the absence of additional appropriations, any additional costs under band 3 would require higher premiums for all band 3 enrollees.

The Department administers the Katie Beckett Model Waiver, which offers Medicaid services to children with severe medical needs who otherwise do not have coverage to pay for the medical services necessary

to manage these children at home. Although the Department expanded the number of waiver slots last year, there remains a significant waiting list of children seeking Katie Beckett .

The department recognizes the challenges faced by parents of children with severe disabilities, but expansion of this service to income band 3 would pose additional funding requirements beyond our current appropriation. Furthermore, we believe the Katie Beckett Model Waiver is the appropriate vehicle to provide this type of support to these medically fragile children. Adding slots to the waiver is an appropriations issue, which is not supported in the Governor's proposed budget.

H.B. No. 6410 (RAISED) AN ACT CONCERNING MEDICAID ELIGIBILITY FOR THE MEDICALLY NEEDY.

Medically needy Medicaid clients are individuals with incomes that exceed the Medicaid Medically Needy Income Limits (MNILs), who must "spenddown" in order to qualify for coverage. In Connecticut, these individuals spenddown by incurring medical expenses in amounts that equal or exceed the amount that their incomes exceed the MNIL during their spenddown period. This is similar to an insurance deductible; individuals are responsible for expenses used to meet their spenddown; however, once their spenddown is met, Medicaid covers expenses subsequently incurred through the end of the spenddown period.

Federal Medicaid rules provide states the option of allowing spenddown clients to pay their spenddown amount to the Medicaid agency at the commencement of the spenddown period and receive Medicaid coverage throughout the spenddown period. At the end of the spenddown period, the Medicaid agency must reconcile the amount that the spenddown client has paid to the agency with the amount of any claims paid by Medicaid. The Medicaid agency must issue a refund to the individual to the extent that amount paid by the individual exceeds the amount of the paid claims.

While the Department recognizes that this option may be of benefit to certain individuals, we cannot support this legislation at this time. Our IT and accounting systems would need to be substantially modified to support the aforementioned reconciliation, which is not currently feasible as we are already in the process of developing a replacement eligibility system and modernizing our IT supports. We have, however, identified this in the scope of work for our replacement eligibility system and may be able to accommodate this option at a later date.

H.B. No. 6411 (RAISED) AN ACT CONCERNING MEDICAID COVERAGE FOR CHIROPRACTIC SERVICES.

We oppose this bill for the reason that it seeks to undo action taken as part of the deficit mitigation agreement which limited chiropractic coverage under Medicaid, specifically, eliminating the state-funded pilot for adults and limiting children's coverage to those services which are medically necessary.

H.B. No. 6412 (RAISED) AN ACT CONCERNING SAFE AND APPROPRIATE TRANSPORTATION FOR NONAMBULATORY MEDICAID RECIPIENTS.

This proposal would prohibit the Commissioner from authorizing the use of stretcher vans. The use of stretcher vans as an alternative to ambulance transportation in specific circumstances was authorized in the December Special Session as part of the deficit mitigation agreement. Accordingly, the department is currently in the process of determining the most effective way to implement stretcher van service in

Connecticut. As with HB 6411, the department cannot support this proposal as it attempts to undo action taken in the deficit mitigation agreement.

H.B. No. 6413 (RAISED) AN ACT CONCERNING MEDICAID ELIGIBILITY AND THE IDENTIFICATION AND RECOVERY OF ASSETS.

Section 1 would allow the exclusion of the cash surrender value of life insurance policies of up to $10,000 when the existence of the policy is the only cause of ineligibility for Medicaid. The Department believes that this provision is intended to address situations where Medicaid applicants are ineligible while they are in the process of surrendering a life insurance policy. These individuals may be ineligible for Medicaid for several months as the process of surrendering a policy can be quite lengthy. Furthermore, the proceeds from the surrendered policy may not be sufficient to pay for the nursing home care provided during the period of ineligibility. As a result, nursing facilities may be owed substantial amounts.

Public Act 12-36, which passed last year, provides a remedy in certain situations. This statute allows individuals to assign the death benefit of life insurance to funeral homes as payment for funeral contracts. When this occurs, the cash surrender value of the life insurance is not counted in determining Medicaid eligibility, nor is the funeral contract. As such, individuals can avoid the often lengthy process of surrendering the life insurance policy and become eligible for Medicaid sooner.

HB 6413 would add a general exclusion of life insurance cash surrender values to the exception allowed under P.A. 12-36. This would largely benefit the beneficiary of the excluded life insurance policy. The Department suggests limiting the exclusion until such time as the life insurance policy is surrendered. The resulting proceeds from the cash surrender value would be regarded as a counted asset once it is received and could be used to pay for long-term care services at the nursing home.

Section 2 would extend the Department's ability to pursue recovery from long-term care Medicaid applicants who transfer assets for purposes of qualifying for assistance, as well as from individuals who receive improperly transferred assets, to nursing facilities. This section would also allow the Department to assess monetary penalties up to double the amount of the value of the improperly transferred assets. The Department does not oppose this provision; however, we do not support the provision that allows the Department to pursue recovery on behalf of nursing facilities and pass through any recovered funds to these facilities. This is administratively burdensome and unnecessary, as other sections of HB 6413 enhance the ability of nursing facilities to pursue recovery independent of the Department.

The department would like to note that the definition of "applied income" in Section 4 is not entirely accurate. The department does not "require" clients to pay applied income to the nursing facility; rather, we reduce the state's payment to the facility by the amount of the applied income. It is the responsibility of the resident to pay their applied income to the facility directly.

H.B. No. 6414 (RAISED) AN ACT CONCERNING NONEMERGENCY MEDICAL TRANSPORTATION FOR MEDICAID RECIPIENTS.

This bill proposes that DSS request a waiver of the CMS requirement that non-emergency medical transportation providers can only be reimbursed when a Medicaid member is transported to or from a Medicaid covered service. The waiver would seek to allow DSS to pay a transportation provider at 50% of their full rate when a member is not picked up because the member does not show up for the appointment. If the reimbursement were allowed, the Department would incur an additional expense of approximately $50,000/month. DSS is working with our non-emergency medical transportation broker to

address the problem of member “no-shows” through other means, including technical adjustments to ensure member addresses are accurate as well as member education efforts.

Furthermore, it is in our opinion, unlikely that CMS would grant a waiver as described in this bill, resulting in 100 percent state obligation for services not delivered. For all of these reasons, the department opposes this legislation.

Thank you for the opportunity to testify before you today. We have brought several members of our staff with expertise in the areas addressed in the bills before you and stand ready to answer any questions you may have.